

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

4098 - 61-029199
STATE FILE NUMBER

AMENDED

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. _____

1. PLACE OF DEATH **AUG 31 1961**
 a. COUNTY **Jackson**
 b. CITY (If outside corporate limits, give TOWNSHIP only) **Kansas City** Length of stay in 1b **70 Yrs**
 c. CITY OR TOWN **Kansas City** Inside Limits Yes No
 c. FULL NAME OF (IF NOT in hospital, give location) **Lewellen Nursing Home** Inside Limits Yes No
 d. STREET ADDRESS **6012 E 15th terr** Reside on Farm Yes No

3. NAME OF DECEASED (Type or print) First **ALFRED** Middle **E** Last **DAVIS**
 4. DATE OF DEATH Month **August** Day **16** Year **1961**

5. SEX **Male** 6. COLOR OR RACE **White** 7. Married Never Married Widowed Divorced
 8. DATE OF BIRTH **10/22/80** 9. AGE (last birthday) **80** IF UNDER 1 YEAR Months _____ Days _____ IF UNDER 24 HR Hours _____ Min. _____

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) **Retired** 10b. KIND OF BUSINESS OR INDUSTRY **Ford Motor** 11. BIRTHPLACE (City and state or country) **Canada** 12. CITIZEN OF WHAT COUNTRY **USA**

13a. FATHER'S NAME **Tom W Davis** 13b. MOTHER'S MAIDEN NAME **Mary Perkins** 14. NAME OF HUSBAND OR WIFE _____

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, or unknown) (If yes, give war or dates of service) **No** 17. INFORMANT Address **Sadie Adkins 6012 E 15th Terr**

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
 PART I. DEATH WAS CAUSED BY:
 IMMEDIATE CAUSE (a) **Congestive Heart failure**
 DUE TO (b) **arterio-sclerosis**
 DUE TO (c) _____
 Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) _____ PART III. If deceased was female was there a pregnancy in last 90 days. Yes No Unknown

19. WAS AUTOPSY PERFORMED? YES NO 20a. ACCIDENT SUICIDE HOMICIDE 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.) _____

20c. TIME OF INJURY Hour _____ a.m. _____ p.m. Month, Day, Year _____

20d. INJURY OCCURRED WHILE AT WORK NOT WHILE AT WORK 20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) **Kansas City, Jackson, Mo** 20f. CITY, TOWN, OR LOCATION **Jackson, Mo** COUNTY **JACKSON** STATE **MO**

21. I attended the deceased from **JUNE 1959** to **aug 16-61** and last saw him alive on **aug 16-61**. Death occurred at **Lewellen Home** **3:45** p.m. on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) **James C Walker M.D.** 22b. ADDRESS **2727 MAIN K.C.MO.** 22c. DATE SIGNED **aug 17-61**

23. BURIAL, CREMATION, REMOVAL (Specify) **Burial** 23b. DATE **8/19/61** 23c. NAME OF CEMETERY OR CREMATORY **Mt Washington Cem** 23d. LOCATION (City, town, or county) **Independence Mo**

24. FUNERAL DIRECTOR **Sheil Funeral Home Kansas City Mo** ADDRESS _____ 25. DATE RECD. BY LOCAL REG. **8-18-61** 26. REGISTRAR'S SIGNATURE **Ruth Long**

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

DATE AMENDED

INSTEAD OF

ITEM NO. SHOULD READ

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

James C. Walker

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me,
or by _____, Student Embalmer No. _____
working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed Thomas A. Hill

Licensed Embalmer No. 4954

P. O. Address J.P. Hill

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license).

If embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.